AMENDED IN ASSEMBLY AUGUST 18, 2016

AMENDED IN ASSEMBLY JUNE 30, 2016

AMENDED IN SENATE MAY 31, 2016

AMENDED IN SENATE MARCH 29, 2016

SENATE BILL No. 908

Introduced by Senator Hernandez

January 26, 2016

An act to amend Sections 1374.21, 1385.03, 1385.07, 1385.11, and 1389.25 of the Health and Safety Code, and to amend Sections 10113.9, 10181.3, 10181.7, 10181.11, and 10199.1 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 908, as amended, Hernandez. Health care coverage: premium rate change: notice: other health coverage.

(1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of its provisions a crime. Existing law provides for the licensure and regulation of health insurers by the Department of Insurance.

Existing law prohibits, among other things, a change in premium rates for group health care service plan contracts and group health insurance policies from becoming effective unless a written notice is delivered, as specified.

This bill would require, if the Department of Managed Health Care or the Department of Insurance determines that a small group rate is unreasonable or not justified, the contractholder or policyholder of a

small group health care service plan contract or health insurance policy to be notified by the health care service plan or health insurer in writing of that determination. The bill would require the notification to be developed by the Department of Managed Health Care and the Department of Insurance, as specified.

Existing law prohibits, among other things, a change in premium rates for individual health care service plan contracts and individual health insurance policies from becoming effective unless a written notice is ~~delivered, as specified. Existing law requires health care service plans and health insurers to limit enrollment in individual health benefit plans to specified open enrollment, annual enrollment, and special enrollment periods. Existing law, subject to certain provisions, requires a health care service plan or health insurer to allow an individual to enroll in or change individual health benefit plans as a result of specified triggering events for the purposes of a special enrollment period.~~ *delivered at least 15 days prior to the start of the annual enrollment period applicable to the contract or 60 days prior to the effective date of the contract renewal, whichever occurs earlier in the calendar year.*

This bill would require, if the Department of Managed Health Care or the Department of Insurance determines that an individual rate is unreasonable or not justified, the contractholder or policyholder to be notified by the health care service plan or health insurer in writing of that ~~determination, and would require, if the open enrollment period has closed for the applicable rate year or there are fewer than 60 days remaining in the open enrollment period for the applicable rate year, the contractholder or policyholder to be given 60 days to obtain other coverage from the existing coverage provider or another provider.~~ *determination.* The bill would require the notification to be developed by the Department of Managed Health Care and the Department of Insurance, as specified. ~~The bill would provide that this notification provided to the contractholder or policyholder constitutes a triggering event for purposes of special enrollment periods in the individual market if the open enrollment period has closed for the applicable rate year or there are fewer than 60 days remaining in the open enrollment period for the applicable rate year.~~ *The bill would instead prohibit a change in premium rates for individual health care service plan contracts and individual health insurance policies from becoming effective unless a written notice is provided at least 10 days prior to the start of the annual enrollment period applicable to the contract or 60 days prior to the*

effective date of the contract renewal, whichever occurs earlier in the calendar year.

(2) Existing law requires a health care service plan or health insurer in the individual or small group market to file rate information with the Department of Managed Health Care or the Department of Insurance, as applicable, at least 60 days prior to implementing any rate change and requires that the information include a certification by an independent actuary that the rate increase is reasonable or unreasonable. Existing law authorizes the Department of Managed Health Care and the Department of Insurance to review these filings to, among other things, make a determination that an unreasonable rate increase is not justified.

This bill would instead ~~require~~ *require, for grandfathered individual and grandfathered and nongrandfathered small group health care service plan contracts or health insurance policies,* a health care service plan or health insurer ~~in the individual or small group market~~ to file rate information at least 120 days prior to implementing any rate change. *The bill would require, for nongrandfathered individual health care service plan contracts or health insurance policies, a health care service plan or health insurer to file rate information either 100 days before the first day of the applicable open enrollment period for the preceding policy year, as defined, or on the date specified in federal guidance issued pursuant to a specified federal regulation, whichever date is earlier.* The bill would require a health care service plan or health insurer to respond to any request for additional rate information necessary for the Department of Managed Health Care or the Department of Insurance to complete its review of the rate filing for products in the individual or small group market within ~~3~~ *5* business days of the request and would ~~require~~ *require, except as provided,* the Department of Managed Health Care and the Department of Insurance to review these filings and make its determination no later than 60 days following receipt of the rate information. *The bill would require, for nongrandfathered individual health care service plan contracts and health insurance policies, the department to make its determination no later than the 15 days before the first day of the applicable open enrollment period for the preceding policy year, as defined, and would authorize the Department of Managed Health Care and the Department of Insurance, respectively, to determine that a plan's or health insurer's rate increase is unreasonable or not justified if the plan or health insurer fails to provide all the information necessary for the respective department to complete its review.*

The bill would require, if the respective department determines that a plan's or health insurer's rate increase for an individual or small group market product is unreasonable or not justified, the health care service plan or health insurer to provide notice of that determination to any individual or small group applicant, as specified.

(3) This bill would also revise obsolete references and would make other conforming and technical, nonsubstantive changes.

(4) Because a willful violation of the bill's requirements with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1374.21 of the Health and Safety Code is amended to read:

1374.21. (a) (1) A change in premium rates or changes in coverage stated in a group health care service plan contract shall not become effective unless the plan has delivered in writing a notice indicating the change or changes at least 60 days prior to the contract renewal effective date.

(2) The notice delivered pursuant to paragraph (1) for large group health plans shall also include the following information:

(A) Whether the rate proposed to be in effect is greater than the average rate increase for individual market products negotiated by the California Health Benefit Exchange for the most recent calendar year for which the rates are final.

(B) Whether the rate proposed to be in effect is greater than the average rate increase negotiated by the Board of Administration of the Public Employees' Retirement System for the most recent calendar year for which the rates are final.

(C) Whether the rate change includes any portion of the excise tax paid by the health plan.

(b) A health care service plan that declines to offer coverage to or denies enrollment for a large group applying for coverage shall, at the time of the denial of coverage, provide the applicant with the specific reason or reasons for the decision in writing, in clear, easily understandable language.

(c) (1) For small group health care service plan contracts, if the department determines that a rate is unreasonable or not justified consistent with Article 6.2 (commencing with Section 1385.01), the plan shall notify the contractholder of this determination. *This notification may be included in the notice required in subdivision (a).*

(2) The notification to the contractholder shall be developed by the department and shall include the following statements in 14-point type:

(A) The Department of Managed Health Care has determined that the rate for this product is unreasonable or not justified after reviewing information submitted to it by the plan.

(B) The contractholder has the option to obtain other coverage from this plan or another plan, or to keep this coverage.

(C) Small business purchasers may want to contact Covered California at www.coveredca.com for help in understanding available options.

(3) In developing the notification, the department shall take into consideration that this notice is required to be provided to a small group applicant pursuant to subdivision (g) of Section 1385.03.

~~(3)~~

(4) The development of the notification required under this subdivision shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

~~(4)~~

(5) The plan may include in the notification to the contractholder the Internet Web site address at which the plan's final justification for implementing an increase that has been determined to be unreasonable by the director may be found pursuant to Section 154.230 of Title 45 of the Code of Federal Regulations.

~~(5)~~

(6) The notice shall also be provided to the solicitor for the contractholder, if any, so that the solicitor may assist the purchaser in finding other coverage.

SEC. 2. Section 1385.03 of the Health and Safety Code is amended to read:

1385.03. (a) All health care service plans shall file with the department all required rate information for *grandfathered* individual and *grandfathered and nongrandfathered* small group health care service plan contracts at least 120 days prior to implementing any rate change. *All health care service plans shall file with the department all required rate information for nongrandfathered individual health care service plan contracts on the earlier of the following dates:*

(1) One hundred days before the first day of the applicable open enrollment period described in Section 1399.849 for the preceding policy year.

(2) The date specified in the federal guidance issued pursuant to Section 154.220(b) of Title 45 of the Code of Federal Regulations.

(b) A plan shall disclose to the department all of the following for each individual and small group rate filing:

(1) Company name and contact information.

(2) Number of plan contract forms covered by the filing.

(3) Plan contract form numbers covered by the filing.

(4) Product type, such as a preferred provider organization or health maintenance organization.

(5) Segment type.

(6) Type of plan involved, such as for profit or not for profit.

(7) Whether the products are opened or closed.

(8) Enrollment in each plan contract and rating form.

(9) Enrollee months in each plan contract form.

(10) Annual rate.

(11) Total earned premiums in each plan contract form.

(12) Total incurred claims in each plan contract form.

(13) Average rate increase initially requested.

(14) Review category: initial filing for new product, filing for existing product, or resubmission.

(15) Average rate of increase.

(16) Effective date of rate increase.

(17) Number of subscribers or enrollees affected by each plan contract form.

(18) The plan’s overall annual medical trend factor assumptions in each rate filing for all benefits and by aggregate benefit category,

including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A plan may provide aggregated additional data that demonstrates or reasonably estimates year-to-year cost increases in specific benefit categories in the geographic regions listed in Sections 1357.512 and 1399.855. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans.

(19) The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual plan contract trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans.

(20) A comparison of claims cost and rate of changes over time.

(21) Any changes in enrollee cost sharing over the prior year associated with the submitted rate filing.

(22) Any changes in enrollee benefits over the prior year associated with the submitted rate filing.

(23) The certification described in subdivision (b) of Section 1385.06.

(24) Any changes in administrative costs.

(25) Any other information required for rate review under PPACA.

(c) A health care service plan subject to subdivision (a) shall also disclose the following aggregate data for all rate filings submitted under this section in the individual and small group health plan markets:

(1) Number and percentage of rate filings reviewed by the following:

(A) Plan year.

(B) Segment type.
(C) Product type.
(D) Number of subscribers.
(E) Number of covered lives affected.
(2) The plan's average rate increase by the following categories:
(A) Plan year.
(B) Segment type.
(C) Product type.
(3) Any cost containment and quality improvement efforts since the plan's last rate filing for the same category of health benefit plan. To the extent possible, the plan shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

(d) The department may require all health care service plans to submit all rate filings to the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF). Submission of the required rate filings to SERFF shall be deemed to be filing with the department for purposes of compliance with this section.

(e) A plan shall submit any other information required under PPACA. A plan shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

(f) (1) A plan shall respond to the department's request for any additional information necessary for the department to complete its review of the plan's rate filing for individual and small group health care service plan contracts under this article within ~~three~~ *five* business days of the department's request or as otherwise required by the department.

(2) ~~The~~ *Except as provided in paragraph (3), the* department shall determine whether a plan's rate increase for individual and small group health care service plan contracts is unreasonable or not justified no later than 60 days following receipt of all the information the department requires to makes its determination.

(3) For nongrandfathered individual health care service plan contracts, the department shall issue a determination that the plan's rate increase is unreasonable or not justified no later than 15 days before the first day of the applicable open enrollment period described in Section 1399.849 for the preceding policy

year. If a health care service plan fails to provide all the information the department requires in order for the department to make its determination, the department may determine that a plan's rate increase is unreasonable or not justified.

(g) If the department determines that a plan's rate increase for individual or small group health care service plan contracts is unreasonable or not justified consistent with this article, the health care service plan shall provide notice of that determination to any individual or small group applicant. The notice provided to an individual applicant shall be consistent with the notice described in subdivision (c) of Section 1389.25. The notice provided to a small group applicant shall be consistent with the notice described in subdivision (c) of Section 1374.21.

(h) For purposes of this section, "policy year" has the same meaning as set forth in subdivision (g) of Section 1399.845.

SEC. 3. Section 1385.07 of the Health and Safety Code is amended to read:

1385.07. (a) Notwithstanding Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code, all information submitted under this article shall be made publicly available by the department except as provided in subdivision (b).

(b) (1) The contracted rates between a health care service plan and a provider shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). The contracted rates between a health care service plan and a provider shall not be disclosed by a health care service plan to a large group purchaser that receives information pursuant to Section 1385.10.

(2) The contracted rates between a health care service plan and a large group shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). Information provided to a large group purchaser pursuant to Section 1385.10 shall be deemed confidential information that shall not be made public by the department and shall be exempt from disclosure under the California Public

Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(c) All information submitted to the department under this article shall be submitted electronically in order to facilitate review by the department and the public.

(d) In addition, the department and the health care service plan shall, at a minimum, make the following information readily available to the public on their Internet Web sites, in plain language and in a manner and format specified by the department, except as provided in subdivision (b). For individual and small group health care service plan contracts, the information shall be made public for 120 days prior to the implementation of the rate increase. For large group health care service plan contracts, the information shall be made public for 60 days prior to the implementation of the rate increase. The information shall include:

(1) Justifications for any unreasonable rate increases, including all information and supporting documentation as to why the rate increase is justified.

(2) A plan's overall annual medical trend factor assumptions in each rate filing for all benefits.

(3) A health plan's actual costs, by aggregate benefit category to include hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

(4) The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual plan contract trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans.

SEC. 4. Section 1385.11 of the Health and Safety Code is amended to read:

1385.11. (a) Whenever it appears to the department that any person has engaged, or is about to engage, in any act or practice constituting a violation of this article, including the filing of

inaccurate or unjustified rates or inaccurate or unjustified rate information, the department may review the rate filing to ensure compliance with the law.

(b) The department may review other filings.

(c) The department shall accept and post to its Internet Web site any public comment on a rate increase submitted to the department during the applicable period described in subdivision (d) of Section 1385.07.

(d) The department shall report to the Legislature at least quarterly on all unreasonable rate filings.

(e) The department shall post on its Internet Web site any changes submitted by the plan to the proposed rate increase, including any documentation submitted by the plan supporting those changes.

(f) If the director makes a decision that an unreasonable rate increase is not justified or that a rate filing contains inaccurate information, the department shall post that decision on its Internet Web site.

(g) Nothing in this article shall be construed to impair or impede the department's authority to administer or enforce any other provision of this chapter.

SEC. 5. Section 1389.25 of the Health and Safety Code is amended to read:

1389.25. (a) (1) This section shall apply only to a full service health care service plan offering health coverage in the individual market in California and shall not apply to a specialized health care service plan, a health care service plan contract in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), a health care service plan conversion contract offered pursuant to Section 1373.6, a health care service plan contract in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), or a health care service plan contract offered to a federally eligible defined individual under Article 4.6 (commencing with Section 1366.35).

(2) A local initiative, as defined in subdivision (w) of Section 53810 of Title 22 of the California Code of Regulations, that is awarded a contract by the State Department of Health Care Services pursuant to subdivision (b) of Section 53800 of Title 22 of the California Code of Regulations, shall not be subject to this section

unless the plan offers coverage in the individual market to persons not covered by Medi-Cal or the Healthy Families Program.

(b) (1) No change in the premium rate or coverage for an individual plan contract shall become effective unless the plan has ~~delivered~~ *provided* a written notice of the change at least ~~15~~ *10* days prior to the start of the annual enrollment period applicable to the contract or 60 days prior to the effective date of the contract renewal, whichever occurs earlier in the calendar year.

(2) The written notice required pursuant to paragraph (1) shall be ~~delivered~~ *provided* to the individual contractholder at his or her last address known to the plan. The notice shall state in italics and in 12-point type the actual dollar amount of the premium rate increase and the specific percentage by which the current premium will be increased. The notice shall describe in plain, understandable English any changes in the plan design or any changes in benefits, including a reduction in benefits or changes to waivers, exclusions, or conditions, and highlight this information by printing it in italics. The notice shall specify in a minimum of 10-point bold typeface, the reason for a premium rate change or a change to the plan design or benefits.

(c) (1) ~~Notwithstanding subdivision (c) of Section 1399.849, if~~ *If* the department determines that a rate is unreasonable or not justified consistent with Article 6.2 (commencing with Section 1385.01), the plan shall notify the contractholder of this ~~determination and, if the open enrollment period has closed for the applicable rate year or there are fewer than 60 days remaining in the open enrollment period for the applicable rate year, shall offer the contractholder coverage of no less than 60 days to obtain other coverage, including coverage from another health care service plan.~~ *determination. This notification may be included in the notice required in subdivision (b).* The notification to the contractholder shall be developed by the department. The development of the notification required under this subdivision shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(2) ~~If it is prior to the open enrollment period for the applicable rate year, the~~ *The* notification to the contractholder shall include the following statements in 14-point type:

(A) The Department of Managed Health Care has determined that the rate for this product is unreasonable or not justified after reviewing information submitted to it by the plan.

(B) During the ~~upcoming~~ open enrollment period, the contractholder has the option to obtain other coverage from this plan or another plan, or to keep this coverage.

(C) The contractholder may want to contact Covered California at www.coveredca.com for help in understanding available options.

(D) Many Californians are eligible for financial assistance from Covered California to help pay for coverage.

~~(3) If there are less than 60 days remaining in the open enrollment period for the applicable rate year or after the open enrollment period has closed for the applicable rate year, the notification to the contractholder shall include the following statements in 14-point type:~~

~~(A) The Department of Managed Health Care has determined that the rate for this product is unreasonable or not justified after reviewing information submitted to it by the plan.~~

~~(B) The contractholder has the option to obtain other coverage from this plan or another plan, or to keep this coverage.~~

~~(C) The contractholder may want to contact Covered California at www.coveredca.com for help in understanding available options.~~

~~(D) Many Californians are eligible for financial assistance from Covered California to help pay for coverage.~~

~~(4)~~

(3) The plan may include in the notification to the contractholder the Internet Web site address at which the plan's final justification for implementing an increase that has been determined to be unreasonable by the director may be found pursuant to Section 154.230 of Title 45 of the Code of Federal Regulations.

~~(5)~~

(4) The notice shall also be provided to the solicitor for the contractholder, if any, so that the solicitor may assist the purchaser in finding other coverage.

~~(6) The notice shall constitute a triggering event for purposes of special enrollment, as defined in Section 1399.849 if the open enrollment period has closed for the applicable rate year or there are fewer than 60 days remaining in the open enrollment period for the applicable rate year.~~

(5) In developing the notification, the department shall take into consideration that this notice is required to be provided to an individual applicant pursuant to subdivision (g) of Section 1385.03.

(d) If a plan rejects a dependent of a subscriber applying to be added to the subscriber's individual grandfathered health plan, rejects an applicant for a Medicare supplement plan contract due to the applicant having end-stage renal disease, or offers an individual grandfathered health plan to an applicant at a rate that is higher than the standard rate, the plan shall inform the applicant about the California Major Risk Medical Insurance Program (MRMIP) (Chapter 4 (commencing with Section 15870) of Part 3.3 of Division 9 of the Welfare and Institutions Code) and about the new coverage options and the potential for subsidized coverage through Covered California. The plan shall direct persons seeking more information to MRMIP, Covered California, plan or policy representatives, insurance agents, or an entity paid by Covered California to assist with health coverage enrollment, such as a navigator or an assister.

(e) A notice provided pursuant to this section is a private and confidential communication and, at the time of application, the plan shall give the individual applicant the opportunity to designate the address for receipt of the written notice in order to protect the confidentiality of any personal or privileged information.

(f) For purposes of this section, the following definitions shall apply:

(1) "Covered California" means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(2) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(3) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 6. Section 10113.9 of the Insurance Code is amended to read:

10113.9. (a) This section shall not apply to short-term limited duration health insurance, vision-only, dental-only, or CHAMPUS-supplement insurance, or to hospital indemnity,

hospital-only, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

(b) (1) No change in the premium rate or coverage for an individual health insurance policy shall become effective unless the insurer has ~~delivered~~ *provided* a written notice of the change at least ~~15~~ *10* days prior to the start of the annual enrollment period applicable to the policy or 60 days prior to the effective date of the policy renewal, whichever occurs earlier in the calendar year.

(2) The written notice required pursuant to paragraph (1) shall be ~~delivered~~ *provided* to the individual policyholder at his or her last address known to the insurer. The notice shall state in italics and in 12-point type the actual dollar amount of the premium increase and the specific percentage by which the current premium will be increased. The notice shall describe in plain, understandable English any changes in the policy or any changes in benefits, including a reduction in benefits or changes to waivers, exclusions, or conditions, and highlight this information by printing it in italics. The notice shall specify in a minimum of 10-point bold typeface, the reason for a premium rate change or a change in coverage or benefits.

(c) (1) ~~Notwithstanding subdivision (c) of Section 10965.3, if~~ *If* the department determines that a rate is unreasonable or not justified consistent with Article 4.5 (commencing with Section 10181), the insurer shall notify the policyholder of this ~~determination and, if the open enrollment period has closed for the applicable rate year or there are fewer than 60 days remaining in the open enrollment period for the applicable rate year, shall offer the policyholder coverage of no less than 60 days in order to obtain other coverage, including coverage from another health insurer.~~ *determination. This notification may be included in the notice required in subdivision (b).* The notification to the policyholder shall be developed by the department. The development of the notification required under this subdivision shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(2) ~~If it is prior to the open enrollment period for the applicable rate year, the~~ *The* notification to the policyholder shall include the following statements in 14-point type:

(A) The Department of Insurance has determined that the rate for this product is unreasonable or not justified after reviewing information submitted to it by the insurer.

(B) During the ~~upcoming~~ open enrollment period, the policyholder has the option to obtain other coverage from this insurer or another insurer, or to keep this coverage.

(C) The policyholder may want to contact Covered California at www.coveredca.com for help in understanding available options.

(D) Many Californians are eligible for financial assistance from Covered California to help pay for coverage.

~~(3) If there are less than 60 days remaining in the open enrollment period for the applicable rate year or after the open enrollment period has closed for the applicable rate year, the notification to the policyholder shall include the following statements in 14-point type:~~

~~(A) The Department of Insurance has determined that the rate for this product is unreasonable or not justified after reviewing information submitted to it by the insurer.~~

~~(B) The policyholder has the option to obtain other coverage from this insurer or another insurer, or to keep this coverage.~~

~~(C) The policyholder may want to contact Covered California at www.coveredca.com for help in understanding available options.~~

~~(D) Many Californians are eligible for financial assistance from Covered California to help pay for coverage.~~

~~(4)~~

(3) The insurer may include in the notification to the policyholder the Internet Web site address at which the insurer's final justification for implementing an increase that has been determined to be unreasonable by the commissioner may be found pursuant to Section 154.230 of Title 45 of the Code of Federal Regulations.

~~(5)~~

(4) The notice shall also be provided to the agent of record for the policyholder, if any, so that the agent may assist the purchaser in finding other coverage.

~~(6) The notice shall constitute a triggering event for purposes of special enrollment, as defined in Section 10965.3 if the open enrollment period has closed for the applicable rate year or there are fewer than 60 days remaining in the open enrollment period for the applicable rate year.~~

(5) In developing the notification, the department shall take into consideration that this notice is required to be provided to an individual applicant pursuant to subdivision (g) of Section 10181.3.

(d) If an insurer rejects a dependent of a policyholder applying to be added to the policyholder's individual grandfathered health plan, rejects an applicant for a Medicare supplement policy due to the applicant having end-stage renal disease, or offers an individual grandfathered health plan to an applicant at a rate that is higher than the standard rate, the insurer shall inform the applicant about the California Major Risk Medical Insurance Program (MRMIP) (Chapter 4 (commencing with Section 15870) of Part 3.3 of Division 9 of the Welfare and Institutions Code) and about the new coverage options and the potential for subsidized coverage through Covered California. The insurer shall direct persons seeking more information to MRMIP, Covered California, plan or policy representatives, insurance agents, or an entity paid by Covered California to assist with health coverage enrollment, such as a navigator or an assister.

(e) A notice provided pursuant to this section is a private and confidential communication and, at the time of application, the insurer shall give the applicant the opportunity to designate the address for receipt of the written notice in order to protect the confidentiality of any personal or privileged information.

(f) For purposes of this section, the following definitions shall apply:

(1) "Covered California" means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(2) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(3) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 7. Section 10181.3 of the Insurance Code is amended to read:

10181.3. (a) All health insurers shall file with the department all required rate information for *grandfathered* individual and *grandfathered and nongrandfathered* small group health insurance

policies at least 120 days prior to implementing any rate change. *All health insurers shall file with the department all required rate information for nongrandfathered individual health insurance policies on the earlier of the following dates:*

(1) One hundred days before the first day of the applicable open enrollment period described in Section 10965.3 for the preceding policy year.

(2) The date specified in the federal guidance issued pursuant to Section 154.220(b) of Title 45 of the Code of Federal Regulations.

(b) An insurer shall disclose to the department all of the following for each individual and small group rate filing:

(1) Company name and contact information.

(2) Number of policy forms covered by the filing.

(3) Policy form numbers covered by the filing.

(4) Product type, such as indemnity or preferred provider organization.

(5) Segment type.

(6) Type of insurer involved, such as for profit or not for profit.

(7) Whether the products are opened or closed.

(8) Enrollment in each policy and rating form.

(9) Insured months in each policy form.

(10) Annual rate.

(11) Total earned premiums in each policy form.

(12) Total incurred claims in each policy form.

(13) Average rate increase initially requested.

(14) Review category: initial filing for new product, filing for existing product, or resubmission.

(15) Average rate of increase.

(16) Effective date of rate increase.

(17) Number of policyholders or insureds affected by each policy form.

(18) The insurer’s overall annual medical trend factor assumptions in each rate filing for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. An insurer may provide aggregated additional data that demonstrates or reasonably estimates year-to-year cost increases in specific benefit categories in the geographic regions listed in Sections 10753.14 and 10965.9. For

purposes of this paragraph, "major geographic region" shall be defined by the department and shall include no more than nine regions.

(19) The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual policy trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

(20) A comparison of claims cost and rate of changes over time.

(21) Any changes in insured cost sharing over the prior year associated with the submitted rate filing.

(22) Any changes in insured benefits over the prior year associated with the submitted rate filing.

(23) The certification described in subdivision (b) of Section 10181.6.

(24) Any changes in administrative costs.

(25) Any other information required for rate review under PPACA.

(c) An insurer subject to subdivision (a) shall also disclose the following aggregate data for all rate filings submitted under this section in the individual and small group health insurance markets:

(1) Number and percentage of rate filings reviewed by the following:

(A) Plan year.

(B) Segment type.

(C) Product type.

(D) Number of policyholders.

(E) Number of covered lives affected.

(2) The insurer's average rate increase by the following categories:

(A) Plan year.

(B) Segment type.

(C) Product type.

(3) Any cost containment and quality improvement efforts since the insurer's last rate filing for the same category of health benefit plan. To the extent possible, the insurer shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

(d) The department may require all health insurers to submit all rate filings to the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF). Submission of the required rate filings to SERFF shall be deemed to be filing with the department for purposes of compliance with this section.

(e) A health insurer shall submit any other information required under PPACA. A health insurer shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

(f) (1) A health insurer shall respond to the department's request for any additional information necessary for the department to complete its review of the health insurer's rate filing for individual and small group health insurance policies under this article within ~~three~~ *five* business days of the department's request or as otherwise required by the department.

(2) ~~The~~ *Except as provided in paragraph (3), the* department shall determine whether a health insurer's rate increase for individual and small group insurance policies is unreasonable or not justified no later than 60 days following receipt of all the information the department requires to make its determination.

(3) For nongrandfathered individual health insurance policies, the department shall issue a determination that the health insurer's rate increase is unreasonable or not justified no later than 15 days before the first day of the applicable open enrollment period described in Section 10965.3 for the preceding policy year. If a health insurer fails to provide all the information the department requires in order for the department to make its determination, the department may determine that a health insurer's rate increase is unreasonable or not justified.

(g) If the department determines that a health insurer's rate increase for individual or small group health insurance policies is unreasonable or not justified consistent with this article, the health insurer shall provide notice of that determination to any individual or small group applicant. The notice provided to an individual applicant shall be consistent with the notice described in subdivision (c) of Section 10113.9. The notice provided to a small group applicant shall be consistent with the notice described in subdivision (d) of Section 10199.1.

(h) For purposes of this section, "policy year" has the same meaning as set forth in subdivision (g) of Section 10965.

SEC. 8. Section 10181.7 of the Insurance Code is amended to read:

10181.7. (a) Notwithstanding Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code, all information submitted under this article shall be made publicly available by the department except as provided in subdivision (b).

(b) (1) Any contracted rates between a health insurer and a provider shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). The contracted rates between a health insurer and a provider shall not be disclosed by a health insurer to a large group purchaser that receives information pursuant to Section 10181.10.

(2) The contracted rates between a health insurer and a large group shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). Information provided to a large group purchaser pursuant to Section 10181.10 shall be deemed confidential information that shall not be made public by the department and shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(c) All information submitted to the department under this article shall be submitted electronically in order to facilitate review by the department and the public.

(d) In addition, the department and the health insurer shall, at a minimum, make the following information readily available to the public on their Internet Web sites, in plain language and in a manner and format specified by the department, except as provided in subdivision (b). For individual and small group health insurance policies, the information shall be made public for 120 days prior to the implementation of the rate increase. For large group health care insurance policies, the information shall be made public for 60 days prior to the implementation of the rate increase. The information shall include:

(1) Justifications for any unreasonable rate increases, including all information and supporting documentation as to why the rate increase is justified.

(2) An insurer's overall annual medical trend factor assumptions in each rate filing for all benefits.

(3) An insurer's actual costs, by aggregate benefit category to include, hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

(4) The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual policy trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

SEC. 9. Section 10181.11 of the Insurance Code is amended to read:

10181.11. (a) Whenever it appears to the department that any person has engaged, or is about to engage, in any act or practice constituting a violation of this article, including the filing of inaccurate or unjustified rates or inaccurate or unjustified rate information, the department may review rate filing to ensure compliance with the law.

(b) The department may review other filings.

(c) The department shall accept and post to its Internet Web site any public comment on a rate increase submitted to the department during the applicable period described in subdivision (d) of Section 10181.7.

(d) The department shall report to the Legislature at least quarterly on all unreasonable rate filings.

(e) The department shall post on its Internet Web site any changes submitted by the insurer to the proposed rate increase, including any documentation submitted by the insurer supporting those changes.

(f) If the commissioner makes a decision that an unreasonable rate increase is not justified or that a rate filing contains inaccurate information, the department shall post that decision on its Internet Web site.

(g) Nothing in this article shall be construed to impair or impede the department's authority to administer or enforce any other provision of this code.

SEC. 10. Section 10199.1 of the Insurance Code is amended to read:

10199.1. (a) (1) An insurer or nonprofit hospital service plan or administrator acting on its behalf shall not terminate a group master policy or contract providing hospital, medical, or surgical benefits, increase premiums or charges therefor, reduce or eliminate benefits thereunder, or restrict eligibility for coverage thereunder without providing prior notice of that action. The action shall not become effective unless written notice of the action was delivered by mail to the last known address of the appropriate insurance producer and the appropriate administrator, if any, at least 45 days prior to the effective date of the action and to the last known address of the group policyholder or group contractholder at least 60 days prior to the effective date of the action. If nonemployee certificate holders or employees of more than one employer are covered under the policy or contract, written notice shall also be delivered by mail to the last known address of each nonemployee certificate holder or affected employer or, if the action does not affect all employees and dependents of one or more employers, to the last known address of each affected employee certificate holder, at least 60 days prior to the effective date of the action.

(2) The notice delivered pursuant to paragraph (1) for large group health insurance policies shall also include the following information:

(A) Whether the rate proposed to be in effect is greater than the average rate increase for individual market products negotiated by the California Health Benefit Exchange for the most recent calendar year for which the rates are final.

(B) Whether the rate proposed to be in effect is greater than the average rate increase negotiated by the Board of Administration of the Public Employees' Retirement System for the most recent calendar year for which the rates are final.

(C) Whether the rate change includes any portion of the excise tax paid by the health insurer.

(b) A holder of a master group policy or a master group nonprofit hospital service plan contract or administrator acting on its behalf shall not terminate the coverage of, increase premiums or charges for, or reduce or eliminate benefits available to, or restrict eligibility for coverage of a covered person, employer unit, or class of certificate holders covered under the policy or contract

for hospital, medical, or surgical benefits without first providing prior notice of the action. The action shall not become effective unless written notice was delivered by mail to the last known address of each affected nonemployee certificate holder or employer, or if the action does not affect all employees and dependents of one or more employers, to the last known address of each affected employee certificate holder, at least 60 days prior to the effective date of the action.

(c) A health insurer that declines to offer coverage to or denies enrollment for a large group applying for coverage shall, at the time of the denial of coverage, provide the applicant with the specific reason or reasons for the decision in writing, in clear, easily understandable language.

(d) (1) For small group health insurance policies, if the department determines that a rate is unreasonable or not justified consistent with Article 4.5 (commencing with Section 10181), the insurer shall notify the policyholder of this determination. *This notification may be included in the notice required in subdivision (a) or (b).*

(2) The notification to the policyholder shall be developed by the department and shall include the following statements in 14-point type:

(A) The Department of Insurance has determined that the rate for this product is unreasonable or not justified after reviewing information submitted to it by the insurer.

(B) The policyholder has the option to obtain other coverage from this insurer or another insurer, or to keep this coverage.

(C) Small business purchasers may want to contact Covered California at www.coveredca.com for help in understanding available options.

(3) The development of the notification required under this subdivision shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(4) The insurer may include in the notification to the policyholder the Internet Web site address at which the insurer's final justification for implementing an increase that has been determined to be unreasonable by the commissioner may be found pursuant to Section 154.230 of Title 45 of the Code of Federal Regulations.

(5) The notice shall also be provided to the agent of record for the policyholder, if any, so that the agent may assist the purchaser in finding other coverage.

(6) In developing the notification, the department shall take into consideration that this notice is required to be provided to a small group applicant pursuant to subdivision (g) of Section 10181.3.

SEC. 11. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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